Medicaid ACH-PCS Cost Settlement

Adult Care Home 7 Beds or More

2007 - 2008

REPORT DUE DATE: JANUARY 31, 2009

Facility Name: _____ Facility Address: _____

County: _____ City, State, Zip Code: _____

License Number: _____ Medicaid Provider Number: _____

NPI Number: _____

FID Number: _____ Cost Reporting Period: From _____ Through _____

Line #	ITEM		AMOUNTS
1.	Total: Personal Care Service Cost		1.
2.	Total: Health Services		2.
3.	Total: Initial/Orientation Aide Training		3.
4.	**Add:**	**[Line #1 plus Line #2 plus Line #3]**	4.
5.	Total: Facility Costs		5.
6.	Total Administration & General Cost		6.
7.	Total: Facility Costs minus Administration Cost	**[Line #5 minus Line #6]**	7.
8.	Administration Cost Factor	**[Divide Line #6 by Line #7]**	8.
9.	Loaded PCS Costs	**[Multiply Line #4 by (Line #8 + 1.00)]**	9.
10.	Resident Days		10.
11.	SA (Medicaid) Days		11.
12.	Medicaid %	**[Divide Line #11 by Line #10]**	12.
13.	Medicaid Loaded PCS Cost	**[Multiply Line #9 by Line #12]**	13.
14.	Medicaid PCS Payment		14.
15.	Balance Now Due:	**[Line #14 minus Line #13 but do not enter less than $ 0.00]**	15.

Line #	Cost Report Schedule References
1.	Schedule C, Line 60, Column 3
2.	Schedule C, Line 80, Column 3
3.	Schedule C, Line 90, Column 3
5.	Schedule C, Line 240, Column 3
6.	Schedule C, Line 120, Column 3
10.	Schedule A, Line 19
11.	Schedule A, Line 20
14.	Schedule B, Line 4

Unpaid Owner/Operator Hours Cost Report Schedule References	List
Schedule C, Line 60, Column 2	
Schedule C, Line 80; Column 2	
Schedule C, Line 90; Column 2	
Schedule C, Line 120, Column 2	
Schedule C, Line 240; Column 2	

Signature of person filling out the form: _____

Telephone Number: _____

MAIL FORM AND BALANCE DUE PAYABLE TO:

Division of Medical Assistance
Finance Management-Rate Setting
2501 Mail Service Center
Attention: Elizabeth Grady
Raleigh, NC 27699-2501

THIS FORM IS NOT TO BE COMPLETED BY FAMILY CARE HOMES [LICENSE TYPE FCL]